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### Controlling chlamydial infection

*The Health of the Nation* target for the reduction in incidence of gonorrhoea has already been achieved in some areas and thus it has become necessary to explore the possibility of substituting targets for other infections. Smith *et al*<sup>1</sup> in Glasgow showed a 12% chlamydia rate in 197 asymptomatic women attending for cervical cytology. In Trent Region a pilot study has been conducted to determine whether a community based chlamydia screening exercise would be a worthwhile undertaking.

One large group practice in Arnold, Nottingham (suburban and four practices in South Lincolnshire (rural) were recruited. Cervical swabs were taken at the time that women attended for routine cytology sampling. Information was collected on the age of patients, on whether they were involved in a stable relationship, and on whether there was a present or past history indicative of urogenital infection. The swabs were processed locally using ELISA (IDEIA) kits and the results were made available directly to the general practitioners concerned. The protocol stated that patients should be referred to the local genitourinary medicine clinic for contact tracing, testing for other sexually transmissible infections and treatment, with an option for the general practitioner to test for other infections and give treatment in case of clinical need before referral for contact tracing.

Age was the only category which provided useful discriminative information. This confirms the findings of Ramstedt *et al*<sup>2</sup> in Sweden and Hunter Handsfield *et al*<sup>3</sup> in the USA. There was no conscious selection for screening among the younger women but clearly from the numbers and yields involved there is an element of self-selection (table).

#### Results of cervical swabs

| Age group (years) | Positive/No tested (%) |                |              |
|-------------------|------------------------|----------------|--------------|
|                   | Suburban               | Rural          | Total        |
| 15-19             | 3/17 (17.6)            | 5/21 (23.8)    | 8/38 (21.1)  |
| 20-24             | 7/62 (11.3)            | 5/64 (7.8)     | 12/126 (9.5) |
| 25-29             | 3/88 (3.4)             | 6/74 (8.1)     | 9/162 (5.6)  |
| 30-39             | 2/179 (4.5)            | 7/156 (4.5)    | 9/335 (2.7)  |
| 40+               | 0/99 (0)               | 2/282 (0.7)    | 2/381 (0.5)  |
| Total tested      | 1042                   | Total Positive | 40 (3.8%)    |

Fortunately it is not necessary to understand this process in order to conclude which age groups satisfy existing criteria of cost effectiveness. However, better definition will be required to evaluate change over time.

Disappointingly, only five out of the 40 positive patients were referred to the local departments of genitourinary medicine. No other patients with positive results were found to have attended the local clinic in the rural area but in contrast the majority of the suburban patients eventually attended. Opportunistic screening and treatment will fail to reduce the prevalence of chlamydia without co-ordinated follow-up and contact tracing.

This study does not tell us whether patients who have once been tested should be retested and if so at what intervals. More importantly we need to develop an initiative which focuses ownership on the medical and nursing staff in general practice, family planning and teenage clinics on whom success finally depends.

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### Genitourinary colposcopy services in the UK

I have recently performed a telephone survey of every genitourinary clinic in England, Wales, Scotland and Northern Ireland. My question was a simple one: "do you perform colposcopy in your clinic?"

It would appear from the answers that of 252 genitourinary clinics 93 provide colposcopy services.

Readers can obtain a copy of the address list and contact name if they would care to send me a stamped addressed A4 size envelope.

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